

Physician's¹ Certificate of Student's Illness or Incapacity to Attend School

To be completed by the parent:

Student name: _____ Date of birth: _____

School: _____ Grade: _____

Parent name: _____ Telephone: _____

To be completed and signed by the physician:

Diagnosis or description of the illness or condition that precluded or currently precludes the student's attendance at school:

Date student first seen by physician for this illness or condition: _____

Date student may be expected to return to school: _____

If unknown, please explain: _____

Date student is to return to be seen by physician: _____

Physician's signature

Physician's printed name

Street Address

City, State, Zip

Telephone number

Date

Please return this form to:

If you have questions, please call:

Tel: _____

¹ This certificate may be completed by an Indiana physician, an individual holding a license to practice osteopathy or chiropractic in Indiana, or a Christian Science practitioner who resides in Indiana and is listed in the Christian Science Journal. IC 20-33-2-18